

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2497
CERTIFICATE OF DEATH

Reg. Dist. No.

02486

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark Ru #1</u>		c. LENGTH OF STAY IN 1b <u>3 mo 4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>E</u> Last <u>Brittingham</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15-1877</u>
9. AGE (In years last birthday) <u>81 1/2</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoeny Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Berlin, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Matthias Brittingham</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jarman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Mrs Della B. Jarman, Snow Hill md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 1958</u> to <u>February 1959</u> , that I last saw the deceased alive on <u>Feb 20</u> , 1959, and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John M. Bender</u>		ADDRESS (Street, city or town, state) <u>104 Bay St. Snow Hill, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John M. Bender</u>		DATE SIGNED <u>104 Bay St. Snow Hill Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Feb 23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Rural md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay B. Gemmis</u>		ADDRESS <u>Snow Hill, md</u>	
24a. RECEIVED BY REGISTRAR <u>FEB 24 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1725 AUG - 30 184

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2495 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02487

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN Ib all life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amelia Colburn		4. DATE OF DEATH Month February Day 24 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min.	11. IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Harriett Ellen Coston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Viola Schoolfield		Address Brooklyn, 340 Frost St. New York,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) German disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Instant (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE N. E. Sartorius Sr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) N. E. Sartorius		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/59	
22c. NAME OF CEMETERY OR CREMATORY Unionville Cem.		22d. LOCATION (City, town, or county) (State) Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Va.		24a. REC'D BY REGISTRAR MAR 2 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT STATE
HEALTH DEPT

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

HEIGHT

WEIGHT

EDUCATION

RELIGION

OCCUPATION

PROFESSION

INDUSTRY

RESIDENCE

STREET

CITY

STATE

DATE OF BIRTH

TIME

PLACE OF BIRTH

DATE OF DEATH

TIME

PLACE OF DEATH

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TIME OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2498

CERTIFICATE OF DEATH

Reg. Dist. No.

02488

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X OCEAN CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 9th St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>WILLETT</u> Last <u>KUBIT</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 11, 1876</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PARISLEY VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WILLETT</u>		14. MOTHER'S MAIDEN NAME <u>DOLLIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MR. JOSEPH W. KUBIT</u>		Address <u>OCEAN CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 y 20</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>30 Jan</u> , 19 <u>59</u> , to <u>4 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4 Feb</u> , 19 <u>59</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ocean City, Md.</u> DATE SIGNED <u>Arthur L. Thomas</u>			
ACTUAL SIGNATURE <u>Arthur L. Thomas</u>		M.D. <u>Ocean City, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Arthur L. Thomas</u>		<u>Ocean City, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 100

<p>1. NAME OF DECEASED (Last, first, middle initial) _____</p>		<p>2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/></p>	
<p>3. AGE (in years and months) _____</p>		<p>4. DATE OF BIRTH _____</p>	
<p>5. PLACE OF BIRTH (City, State, Country) _____</p>		<p>6. OCCUPATION _____</p>	
<p>7. MARITAL STATUS (Married, Single, Widowed, Divorced) _____</p>		<p>8. DATE OF MARRIAGE _____</p>	
<p>9. NAME OF DECEASED'S FATHER (Last, first, middle initial) _____</p>		<p>10. NAME OF DECEASED'S MOTHER (Last, first, middle initial) _____</p>	
<p>11. NAME OF DECEASED'S SPOUSE (Last, first, middle initial) _____</p>		<p>12. DATE OF DEATH _____</p>	
<p>13. PLACE OF DEATH (City, State, Country) _____</p>		<p>14. CAUSE OF DEATH (Specify) _____</p>	
<p>15. SIGNATURE OF DECEASED'S PHYSICIAN _____</p>		<p>16. SIGNATURE OF DECEASED'S NEAREST RELATIVE _____</p>	
<p>17. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL _____</p>		<p>18. SIGNATURE OF DECEASED'S CHURCH CLERK _____</p>	
<p>19. SIGNATURE OF DECEASED'S BURIAL PLACE _____</p>		<p>20. SIGNATURE OF DECEASED'S BURIAL PLACE _____</p>	

REG. NO. 100

1. NAME OF DECEASED (Last, first, middle initial)

2. SEX
 Male ☐ Female ☐

3. AGE (in years and months)

4. DATE OF BIRTH

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION

7. MARITAL STATUS (Married, Single, Widowed, Divorced)

8. DATE OF MARRIAGE

9. NAME OF DECEASED'S FATHER (Last, first, middle initial)

10. NAME OF DECEASED'S MOTHER (Last, first, middle initial)

11. NAME OF DECEASED'S SPOUSE (Last, first, middle initial)

12. DATE OF DEATH

13. PLACE OF DEATH (City, State, Country)

14. CAUSE OF DEATH (Specify)

15. SIGNATURE OF DECEASED'S PHYSICIAN

16. SIGNATURE OF DECEASED'S NEAREST RELATIVE

17. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL

18. SIGNATURE OF DECEASED'S CHURCH CLERK

19. SIGNATURE OF DECEASED'S BURIAL PLACE

20. SIGNATURE OF DECEASED'S BURIAL PLACE

2499

CERTIFICATE OF DEATH

Reg. Dist. No.

02489

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>R.F.D.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM JOSIAH ZUILLEN</u>				4. DATE OF DEATH Month Day Year <u>FEB. 15 1959</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 28, 1886</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ALBERT J. ZUILLEN</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MRS. W. J. ZUILLEN</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: a. IMMEDIATE CAUSE (a) <u>Pulmonary Edema + Anasarca</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Regen. Myocarditis c/o Failure 8 mo</u> DUE TO (c) <u>Chronic Bronchiectasis Bilateral 17 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis Generalized c/o Central Sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1947</u> , 19 <u> </u> , to <u>Feb 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 15</u> , 19 <u>59</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold A. Adams</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin</u>			
PHYSICIAN'S NAME (Type) <u>Manland</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krause</u>			

TO HOSPITAL BY ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2496

CERTIFICATE OF DEATH

Reg. Dist. No.

02490

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				d. STREET ADDRESS R.F.D.# 2 Box 223		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Schoolfield, Jr.		First Middle Last		4. DATE OF DEATH February 25 1959		Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 59 80?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Schoolfield, Sr.				14. MOTHER'S MAIDEN NAME Susian Boston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Raymond Schoolfield, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke, total - secondary to 2 2-3 months 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized, severe - years DUE TO (c) Senile Psychosis, secondary to 2 above. 6 months						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 to Feb. 24, 1959, that I last saw the deceased alive on Feb. 24, 1959, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE N.E. Sartorius, Jr. M.D. Pocomoke City, Maryland PHYSICIAN'S NAME (Type) N.E. Sartorius, Jr., M.D. Pocomoke City, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/59		22c. NAME OF CEMETERY OR CREMATORY Unionville Cem.		22d. LOCATION (City, town, or county) (State) Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - new church, etc.				ADDRESS		24a. REC'D BY REGISTRAR MAR 2 '59	
						24b. REGISTRAR'S SIGNATURE Arthur E. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2500

Items 9 Film G239 2-24-59 et

Reg. Dist. No.

02481

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City 4 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Pocomoke City Md	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS R.D.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Noah First Schoolfield Middle Last		4. DATE OF DEATH Feb 15 - 1959 Month Day Year	
5. SEX M.	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 24 - 1921 31st yrs.
9. AGE (In years) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		10b. KIND OF BUSINESS OR INDUSTRY Chicken farming	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Noah Schoolfield		14. MOTHER'S MAIDEN NAME Cecie Francis Cropper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 225-28-4638	
17. INFORMANT Grace Marie Strugis		Address Pocomoke City Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary disease Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE N. E. Sartorius		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) N. E. Sartorius		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-59	
22c. NAME OF CEMETERY OR CREMATORY St. James		22d. LOCATION (City, town, or county) (State) Pocomoke, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edgar W. Harton - New Church, Va.		24a. REC'D BY REGISTRAR DATE FEB 20 '59	
		24b. REGISTRAR'S SIGNATURE Charles E. Kinard	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
ALBANY, N. Y.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2501 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02492

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City (RURAL)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Ocean City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HERRING CREEK ROAD</u>		d. STREET ADDRESS <u>HERRING CREEK ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMMA KATHERINE TAYLOR</u>		4. DATE OF DEATH <u>Feb 7 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 18 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Ocean City, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-28-2888</u>	
17. INFORMANT <u>Mrs. Earl Pierce</u>		Address <u>Ocean City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY Occlusion Acute</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr.</u>		DATE SIGNED <u>Feb 9, 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/10/59</u>		22b. DATE THEREOF <u>2/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. Burbage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>FEB 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina A. Thoma</u>	

NEW YORK STATE DEPARTMENT OF HEALTH—BALTHAZOR 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2502

CERTIFICATE OF DEATH

Reg. Dist. No.

02493

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Whaleyville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>H.</u> Middle <u>Jull</u> Last		4. DATE OF DEATH <u>Feb.</u> Month <u>25</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Levin Jull</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Godfrey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Rada Jull Long - Seabrookville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular disease</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>5-10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec.</u> 19 <u>56</u> , to <u>Feb. 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 25</u> , 19 <u>59</u> , and that death occurred at <u>7:00 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Grubb, M.D.</u>		ADDRESS (Street, city or town, state) <u>Bay St.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB, M.D.</u>		DATE SIGNED <u>2/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 28, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Whaleyville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry N. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

